DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Date Issued: April 27, 2001

Operational Policy Letter #: 2001.132

To: **Current M+C Organizations** X

CHPP Demonstrations:

Evercare	X
DoD (TriCare)	X
SHMO I & II	X
PACE	

OSP Demonstrations:

MSHO	X
W.P.P.	

HCPPs	
Federally Qualified HMOs	
Section 1876 Cost Plans	X

Subject: **IMPORTANT INFORMATION FOR RENEWING MEDICARE+CHOICE CONTRACTS FOR CY 2002**

Effective Date: April 27, 2001

Implementation Date: April 27, 2001

CALENDAR FOR 2002 M+C RENEWAL PROCESS

2001	
March 30	• CY 2002 ACR, Plan Benefit Package (PBP), and technical instructions become available for download from the Health Plan Management System (HPMS).
May 1	• CY 2002 ACR/PBP Pre-Upload Validation (APV) tool becomes available for download from HPMS. • HCFA notifies M+COs of intent to renew contracts by this date. M+C contracts will accompany renewal letter. • Conference call between HCFA and M+C organizations regarding questions on OPL 2002. Details can be found in Attachment 4.
May 7	• BIPA Section 617 employer group waiver requests due.
May 15	• HCFA will issue a separate OPL on the National Quality Assessment Performance Improvement Project.
May 15-June 1	• Partial County non-renewal requests due to Rosanna Johnson.
June 1	• HCFA begins accepting CY 2002 ACRPs via HPMS.
June 15	• Final day to submit a request for waiver of certain base period (worksheet B), ACRP reporting requirements.
July 2	• Final day for M+COs to submit CY 2002 ACRPs via HPMS. • Note: Section 1876 cost contractors may voluntarily submit a PBP so information on benefits is included in *Medicare & You* and Medicare Health Plan Compare (i.e. Medicare Compare). • Deadline for returning signed M+C contracts to HCFA. • Deadline for submitting non-renewal notices to HCFA. • Final day for M+COs to submit CY 2002 capacity limits.
July 10	• Final date for M+COs to submit **CY 2001** marketing materials for HCFA's review and approval.
July 19	• M+COs should submit CY 2002 summary of benefits (SB) and annual notice of change (ANOC) materials to HCFA regional offices to allow sufficient time for HCFA's review and approval before the September 17 publication of "Medicare Compare."
July 18-24	• M+COs preview the *Medicare & You*, CY 2002 items prior to HCFA publication.
August 3	• HCFA begins printing *Medicare & You*, CY 2002.

September 1	• Tentative date for HCFA's approval of all CY 2002 renewal ACRPs. • Final date to send ANOC materials (including summary of benefits) to HCFA regional offices in order to ensure review and approval before October 15 deadline. • HCFA begins CY 2002 local information campaign. • M+COs required to include information in CY 2001 marketing and enrollment materials to inform potential enrollees about the possibility of plan (benefit) changes beginning January 1, 2002.
September 1-October 1	• HCFA mails *Medicare & You* for CY 2002.
September 4-6	• M+COs preview "Medicare Compare" plan data prior to release on the Internet.
September 17	• HCFA publishes "Medicare Compare" data on the Internet.
October 14	• Final date for marketing CY 2001 plans (i.e., benefit packages) to Medicare beneficiaries through public media.
October 15	• M+COs begin marketing CY 2002 benefits to Medicare beneficiaries through public media. • CY 2002 ANOC letters (with summary of benefits) due to beneficiaries. M+COs must mail ANOC letters before this date to ensure receipt by beneficiaries by October 15. • *Note: All marketing presentations and mailings to beneficiaries who inquire about CY 2002 enrollment must include a CY 2002 summary of benefits.*
November 1-30	• Annual election period (all M+COs).

2002	
January 1	• Effective date for CY 2002 plan benefits.
January 15	• Tentative deadline for distributing CY 2002 EOCs to plan members.

Summary of Important Changes for Contract Year 2002

I. Statutory and Regulatory Changes -- Benefits Improvement and Protections Act of 2000 Implementation (BIPA)

Update on BIPA Implementation

Title VI of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) changed the Medicare+Choice (M+C) program. BIPA requires the Health Care Financing Administration (HCFA) to revise and/or change several of the current regulations under Part 422. Some of these provisions are effective in the near future or have already taken effect, e.g., the expansion of the new entry bonus (effective on enactment) and revised M+C payment rates for contract year (CY) 2001 (effective March 1, 2001). Implementing the revisions required under BIPA will require the publication of revisions to current regulations. We have divided the BIPA provisions into two separate regulations. One regulation will incorporate those provisions of BIPA that provide clear and specific direction to HCFA and would not require significant policy interpretation. We intend to publish the first regulation in the summer. The second regulation will incorporate those provisions of BIPA that do not provide as clear and as specific direction to HCFA. Some of the rules contained in this regulation may require significant policy interpretation. The second regulation will take longer to publish; HCFA expects to issue it this fall.

Reference to BIPA letter

In February 2001 HCFA released a letter about the implementation of BIPA. That letter can be found on the Internet at: http://www.hcfa.gov/medicare/bipaletter.htm

Local Medical Review Policies

Medicare+Choice organizations (M+COs) are required to provide their Medicare enrollees with those services that are covered under Medicare and available to other fee-for-service Medicare beneficiaries residing in the geographic area covered by the plan. Currently, in accordance with 42 CFR 422.101, Medicare M+COs must comply with HCFA national coverage decisions and "local medical review policies" (LMRPs).

Pursuant to BIPA Section 615, an M+CO offering an M+C plan in an area with more than one local coverage policy would be able to elect to have the local coverage policy for the part of the area that is most beneficial to M+C enrollees apply to all M+C enrollees enrolled in the plan.

LMRPs may be found on the Internet at www.lmrp.net. This Web site is updated quarterly. LMRPs finalized by the local contractor between updates may be found on the local contractor's Web site.

Quality Assurance Program focus on Racial and Ethnic Minorities
Section 616 of BIPA requires that M+C quality assurance programs be expanded to include a separate focus on racial and ethnic minorities. This focus applies to a M+CO's overall quality assurance program. During the first quarter of 2002, each M+CO must report to HCFA what actions it has taken to implement Section 616. HCFA will provide an optional tool for use in preparing this biennial report later this year.

Compatibility With Employer Group Plans
To fully implement section 617 of BIPA, HCFA will promulgate a regulation that spells out under what conditions provisions can be waived to allow for "Medicare+Choice Program compatibility with employer or union group health plans."
In the meantime, HCFA will consider waiver proposals under Section 617 using the discretionary authority of the Secretary to decide what can be waived under the very broad waiver authority that section 617 provides ("the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in, Medicare+Choice plans" under M+C contracts with employers and unions).

At this time, HCFA is soliciting waiver requests from M+C organizations as part of the ACR instructions. For this initial round, we are recommending that your requests only address provisions that will affect your ACR proposals. Waiver requests should be submitted by May 7, 2001 to OPL2002@hcfa.gov. The request will first be evaluated to determine if it falls within the parameters of the BIPA Authority. The feasibility of the desired implementation date will also be examined. We will notify all M+C organizations through a website posting of those requests that have been approved for waiver. Our goal is to have decisions by June 1, 2001. Waiver requests should include in writing: what provisions you would like waived, how this waiver will facilitate compatibility with employer group plans, how a waiver of such a provision will affect your ACR proposals, and a general estimate of the burden, and/or administrative costs, that will be reduced by granting such a waiver. Waiver requests for other provisions [e.g. marketing, enrollment] can be included in this process but we cannot guarantee that we will be able to act upon these requests prior to the submissions of your ACRs.

It is HCFA's intention to solicit and act upon requests for waivers on an ongoing basis. We are currently developing instructions to guide plans in making waiver submissions and to provide a basic understanding of the HCFA approval process. For example, it may be determined that the waiver request is complex in nature and must be pilot tested before HCFA would consider adopting the procedure nationally or the proposal may require additional HCFA resources that may not be available within the desired timeframe. Some proposals could be rejected initially in favor of having such proposals included in a Notice of Proposed Rulemaking for the purpose of obtaining broader public comment. At the same time, provisions that were waived in the initial round under the Secretarial waiver authority could change to non-waivable provisions as a result

of the regulatory process.

Actuarial Review of Adjusted Community Rate Proposals
Section 622 of BIPA requires the Chief Actuary of the Health Care Financing Administration to review actuarial assumptions and data used by Medicare+Choice organizations (M+CO) during the preparation of their Adjusted Community Rates (ACR) proposals. HCFA's actuaries shall review actuarial rates, amounts, and assumptions used to develop the values that appear on the ACR worksheets to determine their appropriateness. The effective date for the implementation of Section 622 is May 1, 2001 and shall apply to any ACR submitted on or after that date.

In conjunction with the Section 622 provisions, HCFA expects to perform on-site actuarial reviews to be conducted as part of the annual audit process. Additionally, HCFA is asking M+COs to submit an actuarial certification for each ACR proposal, to be signed by the M+CO's actuary, or its consulting actuary, attesting to the appropriateness of the actuarial methods and assumptions underlying the ACR submission. While the following language is recommended, comparable language would similarly signify to HCFA that the actuarial assumptions in question have been prepared following Actuarial Standards of Practice.

I certify, that to the best of my knowledge and judgment, the data, actuarial assumptions, and actuarial methods underlying this Adjusted Community Rate Proposal conform to the appropriate Actuarial Standards of Practice, as promulgated by the Actuarial Standards Board, and that the results reasonably reflect the statutory purpose for which the estimates are prepared. Furthermore, I believe that the benefits provided by this plan are reasonable in relation to the total of the Medicare capitation payments and enrollee premiums.

A signed statement should be labeled "Attachment 2" and included with the ACR documentation immediately behind the Initial Rate documentation.

Election Periods for 2002 -- Start of "Lock-in"
Pursuant to Section 1851(e)(2)(B) of the Social Security Act, HCFA is implementing various election period provisions in 2002. These changes in enrollment and disenrollment rules are commonly referred to as the "lock-in" provisions.

- The open enrollment period (OEP) for 2002 is only from January through June. M+C organizations have the option of opening or closing their M+C plans during this time, and beneficiaries may make a single change in election during these months. All plans, including the Original Medicare Plan, will be closed between July through October and in December, except for initial coverage elections, special elections, and the limited OEP exceptions listed below (refer to OPL 99.100 for a complete discussion of election periods, including special election periods). Aside from these exceptions, beneficiaries will not be permitted to join new M+C plans or disenroll to the Original Medicare Plan during this time.

As a result of the OEP changes, HCFA will need to update many of the exhibits from OPL 99.100. We will be making changes to those model forms and notices during the upcoming year. M+C organizations will need to modify enrollment/disenrollment forms and letters accordingly.

Reminder: Beneficiaries who are making their election via an employer group health plan arrangement are given a special election period and will not be affected by the "lock-in" rules.

- Institutionalized individuals are not subject to the new limitations on the OEP. M+C organizations have the option to be continuously open throughout the entire year to accept institutionalized individuals.

- OEPNEW -- An OEP (OEPNEW) exists for newly eligible individuals. These individuals have an additional option to change their election during their first 6 months of eligibility or December 31, 2002, whichever comes first. M+C plans are permitted but not required to accept elections by individuals during their OEPNEW.

- SEP65 --An additional special election period will be available to individuals who become entitled to Medicare coverage on turning age 65 and who choose an M+C plan. These individuals will have the opportunity to return to the Original Medicare Plan within 12 months of their enrollment in an M+C plan.

- Involuntary disenrollments are not considered elections. Therefore, the ability of M+C organizations to process involuntary disenrollments is not constrained by the lock-in rules.

A letter describing systems requirements for implementing "lock-in" was released on March 23,2001. This letter will be updated to reflect the following and it will be posted at WWW.HCFA.GOV/Medicare/Systinfo.htm. It will be labeled as Revised and dated April, 25, 2001.

The above "lock-in" provisions are effective January 1, 2002, and as of that date, an enrollee's ability to make an election of another M+C plan (including one offered by the same M+CO as the plan in which he or she is enrolled), is limited as described above. In the case of a change in election between M+C plans offered by the same M+CO, the M+CO should keep track of such elections in order to enforce the above-described statutory limits. While M+COs thus must be able internally to identify the M+C plan in which one of its Medicare members is enrolled, we are granting M+COs until the June 2002 Plan Data Due Date to adapt their systems to report this information to HCFA. Beginning July 1, 2002, the Transaction/Reply and Monthly Membership Reports will contain PBP information.

Enrollment Changes

The return to the first of the month effective date rule (Section 619 of BIPA) and the ESRD enrollment provisions for individuals in terminating plans (Section 620 of BIPA) are described in more detail on HCFA Web pages.

As of June 1, 2001, effective dates for elections made during open enrollment will be the first of the month after the election is received -- see http://www.hcfa.gov/medicare/bipaletter.htm.

For additional information on how HCFA's managed care system will implement aspects of Section 620, see http://www.hcfa.gov/medicare/systems1.htm

II. Administrative Changes for 2002

M+C Compliance Burden study

To date, our contractor PriceWaterhouseCoopers (PwC) has completed interviews with eight M+COs, three industry trade associations, two beneficiary advocacy organizations, and four provider organizations. PwC reports that participants generated a great deal of information, and they are completing analysis of the results. We plan to release their findings in May.

Based on discussions with PwC about their preliminary analysis of the results, we note that changes in the treatment of Value Added Items and Services (VAIS) and the display of supplemental benefits (discussed in Section III) address interviewees' concerns.

M+C Contractor Performance Monitoring System (MCPMS) Guide Revision

Beginning January 1, 2002, HCFA will start using a revised MCPMS Guide during monitoring reviews of M+COs. The revised Guide will eliminate duplication, have methods of evaluation (MOEs) that are exclusive to one element only, be based on more quantitative methods, and follow the order of the upcoming M+C Manual. Later this year, HCFA will release a draft of the revised MCPMS Guide to M+CO and industry representatives for comment.

Deeming

HCFA is in the process of establishing an M+C Deeming Program. Once a private, national accrediting organization has been approved for deeming authority, an M+CO may elect to be deemed in compliance in the areas that the accrediting organization has authority to deem. An accrediting organization may seek deeming authority for any or all six of the deeming areas: quality assurance, anti-discrimination, access to services, confidentiality and accuracy of enrollee records, information on advance directives, and provider participation rules. To be approved, an accrediting organization must demonstrate that their program meets or exceeds the Medicare requirements for which they are seeking the authority to deem compliance.

HPMS Voluntary Plan Closure Module

In May 2001, HCFA will implement a new HPMS module that will enable M+COs to enter and update their voluntary plan closure data. Specifically, M+COs will be able to record whether their plan is voluntarily closed for an entire month or a group of months, for a part of a month or group of months, or for non-consecutive intervals during a month or group of months. In addition, M+COs will be asked to provide the date on which the corresponding public notification materials were sent to the HCFA Regional Office (RO), the date on which these materials were published, and the newspapers in which they were published. HCFA's Center for Beneficiary Services (CBS) will use the M+CO-entered data in the HPMS Voluntary Plan Closure module to create and post closure messages in both Medicare Health Plan Compare

and the *Medicare & You* Handbook. Technical instructions will be made available either before or at the time of the module's release.

Encounter Data Attestations

In contract year 2001, M+COs began the submission of two additional types of encounter data: outpatient services and physician services. These additional data do not affect payment until 2004 and will require attestation in 2003. Attachment B of the M+C contract has been modified to include the outpatient and physician data, however, in 2002 only inpatient hospital data requires attestation. Later this year, HCFA will issue further instructions for the attestation of all encounter data. These instructions will include a timeline for certification of encounter data that affect payment and due dates for these attestations.

Monthly Enrollment Certification

Consistent with the statute enacted last year giving legal force to electronic signatures, HCFA is developing a demonstration program under which M+C organizations will submit their monthly enrollment data certifications electronically. Later this summer, HCFA will be soliciting volunteers among M+C contractors (approximately 20) to participate in this project. The demonstration is expected to continue for one year, at which time HCFA will evaluate the technology and the processes connected with electronic certification and consider adopting the requirement for all M+C organizations.

Enhanced Payments for Congestive Heart Failure (CHF)

Beginning January 1, 2002, M+COs that meet certain quality thresholds will be eligible to receive extra payments for their members that had a primary diagnosis of CHF if they choose to participate in the activity beginning in 2001. OPL 2000.129 describes the requirements and the associated payment methodology. Basically, the population will include those with inpatient discharge diagnoses of CHF between July 1999 through June 2001. Depending on when the discharge occurred in relation to the payment year, M+COs will receive extra payment based on 1/3 of PIP-DCG 16 amount. All payments will be subject to the risk adjuster transition blend of 10%.

Appeals Data Requirements

To implement 42 C.F.R. Section 422.111(f)(10)(iv) and 422.502(f)(2)(v), M+COs are to begin reporting the aggregate appeals data they currently collect at the M+CO level to HCFA's HPMS. The appeals data elements that M+COs would be expected to report to HCFA are 15 of the same data elements that M+COs currently report to beneficiaries upon request (see attached explanation of the data elements that M+COs will report consistent with OPL 99.081), with the exception of quality-of-care grievances. (We have more work to do and intend to formalize a "grievance" definition through our current Notice of Proposed Rulemaking).

In order to report data to HCFA, M+COs should adhere to the same collection and reporting cycles that they are already implementing to comply with OPL 99.081. In other words, the two six-month data collection cycles that begin each year starting on April 1 and ending on September 30, and the other starting on October 1 and ending on March 31, would continue on the same schedule. M+COs would have an opportunity to reconcile any discrepancies or missing information in the 3-month period immediately following the six-month data collection cycles (e.g. October 1, 2002), and would then be expected to input their data to HCFA's HPMS Web site by January 1, 2003. Under a separate cover, we will issue an OPL communicating how the M+COs are to enter their data in the Web-based tool, including an advanced copy of the screens and tools needed to report the data.

Below is a chart detailing the yearly collection and reporting cycles for 2002.

6-month Data Collection	3-month Reconciliation	Transmit Data to HCFA	What kind of data?
4/1/02 - 9/30/02	10/1/02-12/31/02	1/1/03	last 6 months
10/1/02 - 3/31/03	4/1/03-6/30/03	7/1/03	last 12 months
4/1/03 - 9/30/03	10/1/03-12/31/03	1/1/04	last 12 months, etc.

Standardized Notices

Pursuant to 42 CFR Section 422.568(d), an M+CO is required to issue a notice when it denies an enrollee's request for medical service, or whenever there is a request for payment for services already received. Instead of using model denial notices that are currently part of the marketing guidelines package, HCFA announced its intent to develop two standardized appeal notices: the Notice of Denial of Medical Services and the Notice of Denial of Request for Payment. Information pertaining to these notices was published in the Federal Register on June 8, 2000 and March 22, 2001. We have just completed the last public comment period for approval by the Office of Management and Budget (OMB) consistent with the Paperwork Reduction Act process, and anticipate final clearance by OMB by July 1, 2001. The June 8, 2000 draft notices were reduced in the March 22, 2001 version to one page (double-sided), or two one-sided pages. We believe these drafts respond to the issues that were raised by the public. Therefore, we intend to issue a final notice, ready for an M+CO's usage, by July 1, 2001, and then require use of the notices by all M+C organizations by January 1, 2002. Using the standardized notices will eliminate the burden of M+C organizations meeting the 45-day marketing approval process. For pricing purposes, M+C organizations should account for their costs in administering appeals using these new two-page forms.

Focused Review of Appeals Under the Grijalva settlement
The Grijalva Settlement Agreement, in Sections C.2. and C.3., requires a Monitoring Strategy that includes focused reviews of appeals information. These reviews will be based on formulas developed from data received from two HCFA Consumer Assessment of Health Plans Surveys (CAHPs) and the current independent review entity (CHDR). Also, the monitoring strategy will involve methods of detecting non-compliance with appeals requirements.

Important Message From Medicare (IM)--HCFA-R-193-M+C
Upon OMB approval, the IM will replace the existing inpatient hospital discharge notice, i.e., the Notice of Discharge & Medicare Appeal Rights (NODMAR). Hospitals will be required to give this notice to all Medicare beneficiaries at or about the time of admission and near the time of their discharge. Regarding M+C enrollees, hospitals will need to distribute this notice to the enrollee no later than one day before inpatient hospital coverage ends. Therefore, M+C organizations are required to give hospitals the enrollee's first date of noncoverage before inpatient hospital coverage ends. This will allow hospitals to meet the timeliness requirement for issuing the notice. A forthcoming OPL will be written to explain, in detail, the operational and policy aspects of this requirement on PROs, hospitals, and M+C organizations. See Attachment 2.

HIPAA
The Health Insurance Portability and Accountability Act of 1996 requires the Department of Health and Human Services to adopt a set of national Electronic Data Interchange (EDI) standards for the health care industry. The Department was to adopt standards for (1) transactions and code sets, (2) identifiers for health plans, providers, employers, and individuals for use in the transactions, (3) security of health information, and (4) privacy of health information. The law provided for a 2-year implementation period for each of the adopted sets of standards. The 2-year period begins on the effective date of the regulation that adopts the standard.

Because the Medicare and M+C contracting organizations are designated as health plans, HCFA is responsible for assuring that the adopted standards are implemented in these programs. While HCFA understands that M+COs have the responsibility to learn about the standards, conduct the systems work, and communicate with providers, HCFA will provide information and assistance. Information about these HCFA activities will be issued separately.

III. Renewal Process

2002 M+C Contract

HCFA has drafted new contracts for organizations offering M+C coordinated care and private fee-for-service plans during 2002. The most significant change from the existing M+C contract is that the 2002 contract is renewable, as authorized under Section 1857(c)(1) of the Social Security Act and 42 CFR 422.504. Since the inception of the M+C program in January 1999, HCFA has required M+C organizations to sign one-year contracts because of the evolving nature of the new program's requirements. With the publication of the final M+C rule in June 2000, HCFA has completed the process of drafting the regulatory requirements for the M+C program, making the use of a renewable M+C contract appropriate. The majority of the other revisions to the contract make existing provisions consistent with a renewable contract.

The renewable contract will reduce the administrative burden on both HCFA and the M+C organizations and will return the contract renewal process to the system used under section 1876 of the Social Security Act, prior to the implementation of the M+C program. HCFA will continue to provide a notice by May 1 of each year to each M+C organization of its decision to renew an organization's M+C contract. M+C organizations, on the other hand, need not take any action to renew their M+C contracts. However, organizations must provide a notice to HCFA by July 1 to indicate a decision to non-renew their contract.

It is important to note that the 2002 contract retains two 2001 contract provisions originally drafted in response to managed care industry concerns. First, the 2002 contract contains a provision requiring HCFA to inform M+C organizations of any new requirements resulting in significant new operational costs one month before the ACR submittal date of the year prior to the contract year. Second, the 2002 contract retains the provision allowing organizations to terminate their contract if HCFA does not approve their ACR proposal before September 30 of the year prior to the contract year.

General ACRP Information

All ACRs and PBPs for CY 2002 must be submitted to HCFA no later than July 2, 2001. M+COs must obtain the ACR and PBP software from HCFA's HPMS. All M+COs must use HPMS to submit their ACRPs electronically. HPMS will begin accepting ACRP data uploads on June 1, 2001. In addition, M+COs must submit a hard copy of the ACR (including signatures) and supporting documentation postmarked no later than July 2, 2001.

For CY 2002, HCFA will continue to require all M+COs to identify a primary contact for the ACRP process with responsibility for all M+C plans submitted by the M+CO. HCFA will work directly with this person during the ACRP review and approval process. This important information must be provided to HCFA at the time an organization obtains its ACR/PBP forms.

Worksheet A of each and every M+C plan's ACR submitted July 2 must have all three signatures on the certification. In prior years, one set of signatures was sufficient for all ACRs of the same plan type (e.g., HMO, HMOs with a POS option). Due to confusion that arose during the desk reviews and the ACR audits, signatures are now required on ALL ACRs submitted by July 2. Subsequent resubmissions may or may not require signatures. See the ACR instructions located on HCFA's Web site for more details.

In accordance with federal regulations at 42 CFR 422.306(a), HCFA will again require that M+COs provide historical cost information for each health care component (lines 1 to 19 of the ACR). We expect that all organizations can now report historical cost information for each health care component. Nevertheless, some M+COs (e.g., new contractors) may need to request a waiver of this requirement. If so, the M+CO must notify HCFA, in writing, by June 15, 2001. The notice must describe the reasons why the organization cannot meet HCFA requirements, should include a proposed alternative method for reporting costs, and should indicate how the organization will adapt its systems to permit reporting historical data for each component in contract year 2003. Please note that waivers do not apply to the reporting of cost-sharing amounts on Worksheet C of the ACR. M+COs should e-mail all requests for waiver of ACR reporting requirements for Worksheet B to ACRCostCombine@hcfa.gov. In addition, organizations must include a copy of the notice in the July 2 ACRP submission.

Any capacity limit number placed in the ACR should be based on current enrollment figures and perceived capacity limit needs. A formal capacity limit request is still required. For information on this process, please refer to OPL #95.

All information on the ACRP process, including instructions to complete and submit the ACR and PBP, model marketing materials, and frequently asked questions, will be posted on HCFA's Web site at www.hcfa.gov/medicare/acrp.htm.

ACR Worksheet Changes

The ACR Worksheets for contract year 2002 have incurred minimal changes, most of which are transparent to the user. The two most apparent changes are described below.

In prior years, the Medicare Deductible and Coinsurance per member per month (PMPM) amount and the Medicare Psychiatric Co-payment PMPM amount appeared on separate lines within the ACR. The contract year 2002 ACR combines those amounts into one line (Worksheet A, Part IA, line 11 and Worksheet E, line 16).

Adjustments to additional revenue can be made for various reasons. For example, adjustments can be made to correct errors on Worksheet E, to reflect state-mandated requirements, and/or to make the additional revenue values more precise. In prior years, Worksheet D contained

only one line for expected variations related to additional revenue. For contract year 2002, Worksheet D has three separate lines for adjustments to additional revenue. The first line must reflect only adjustments to eliminate the error message on Worksheet E or to improve the precision of the additional revenue values. Use the second line (under column b, Medicare-covered benefits) only when the Adjusted ACR (Worksheet E, line 7) is greater than the Average Payment Rate (Worksheet E, line 1). If this situation occurs, an adjustment must be made to additional revenue to equalize the adjusted ACR and the APR. The third line must be used to reflect state-mandated requirements (e.g., financial requirements). See the ACR instructions located on HCFA's Web site for more details.

Mid-Year Benefit Enhancements and ACR Submittals

M+C regulations issued in June 1998 provided for a "transition period" prior to January 1, 2002, during which HCFA expressly authorized organizations to request HCFA approval of mid-year changes that would enhance benefits or reduce premiums and/or cost sharing. These regulations were silent on what rules applied after January 1, 2002. We have elected to continue after January 1, 2002 to permit M+COs to enhance benefits or reduce premiums and/or cost sharing in the manner previously authorized by regulation only for periods prior to January 1, 2002. HCFA will begin accepting proposals for mid-year benefit enhancements for CY2002 plans on November 1, 2001, and continuing through August 2002. Proposed enhancements to M+C plans will be effective no earlier than February 1, 2002. Refer to OPL #107 for more information on ACR and PBP submission requirements.

ACR Submittals for New M+C Contracts Beginning After January 1, 2002

In the same "transition period" rule mentioned above, prior to January 1, 2002, HCFA would permit M+C organizations to submit ACRs on a date other than July 1 if their contract period was to begin on a date other than January 1. In the final rule published in June of 2000, HCFA eliminated the restriction on mid-year contracts after January 1, 2002. While HCFA recognized that once the lock-in takes effect, an M+CO entering an area mid-year would only be able to enroll individuals who are newly eligible, or who are eligible for a Special Election Period, HCFA determined that if an M+CO nonetheless wished to do so, HCFA would permit this. Therefore, after January 1, 2002, M+COs will maintain the ability to begin a contract mid-year when entering a new area. Such a new contract would initially be for a period of more than 12 months.

M+C Extended Enrollment Options limited to six months

M+C plans can offer out-of–area benefits (such as a POS or a visitor/traveler benefit) for their enrollees who have temporarily left their plan's service area. However, even with an out-of-area benefit, enrollees must be disenrolled from their plan after six months of continuous absence from their plan's service area (see 42 CFR section 422.74(d)(4)).

Optional Supplemental Benefits

In previous years, neither Medicare Compare nor the benefits matrix of the Summary of Benefits displayed optional supplemental benefit options available to enrollees of a particular M+C plan. As a result, Medicare beneficiaries lacked a clear explanation of all available benefits offered by M+C organizations. In response, many M+COs created separate M+C plans to offer different benefit combinations, when it may have been more appropriate to offer these benefit packages as enrollee options under a single M+C plan.

HCFA has now made appropriate changes to the Plan Benefit Package to display information concerning optional supplemental benefits in both the Summary of Benefits and Medicare Compare. Therefore, M+C organizations that will be offering optional supplemental benefits in 2002 will *not* need to create a separate M+C plan, and file a separate ACR, in order to have a information on the benefit options displayed for beneficiaries. These changes address concerns raised by M+COs, and provide for the submittal of fewer ACRPs, thus reducing the burden on M+COs.

For example, consider an M+CO that wants to submit two plans of the same type (e.g., HMO). Plan 001 with an optional supplemental prescription drug benefit and Plan 002 offering the same benefits except there is no drug benefit. In that case, the M+CO could submit one plan (i.e., one ACR and PBP) with the prescription drug benefit as an optional supplemental benefit for enrollees of that M+C plan.

Optional supplemental benefits should be priced individually in the ACR. Furthermore, optional supplemental benefits should be described in the PBP in the data entry elements of the appropriate benefit category. In cases where the plan offers more than one optional supplemental benefit within the same category, the "step-up" should be described in the note section of the appropriate benefit category.

While optional supplemental benefits must be priced and described individually, they may be packaged together in marketing documents. However, the overall premium for the package must be equal to the sum of the premiums for each individual benefit.

Health Plan Management System (HPMS)

HPMS Access

M+COs must use the Health Plan Management System (HPMS) to electronically submit their ACRs and PBPs for Contract Year (CY) 2002. The HPMS Extranet requires that M+COs establish connectivity to the Medicare Data Communications Network (MDCN), a secure network maintained for HCFA by AT&T Global Services (AGS). After establishing connectivity to the MDCN, M+COs will access HPMS at http://32.82.208.82/ using the Microsoft Internet Explorer browser version 4.01 or higher.

M+COs should refer to OPL #101, "Migration of Medicare Managed Care Organizations to the Medicare Data Communications Network (MDCN) for Health Plan Management System (HPMS) Access," for technical direction on accessing HPMS via the MDCN.

HCFA also requires that all users obtain a HCFA Identification Tracking System (HITS) user ID to access HPMS. HCFA will use the HITS user ID to authenticate user access rights and apply the appropriate security levels. Please contact Don Freeburger at either 410-786-4586 or DFreeburger@hcfa.gov to obtain a HITS user ID.

HPMS Update

HCFA has implemented the following HPMS updates for the CY 2002 ACRP renewal process:

- M+CO Contact Information. For CY 2002, M+COs will continue to use this HPMS module to enter and maintain their organization and plan level contacts. HCFA has reengineered this module to enable M+COs to enter a contact person a single time and then associate that contact to multiple roles, organizations, and plans. This new functionality will help to reduce the amount of data entry required to populate these M+CO contacts. The M+CO contacts being collected for CY 2002 include the following:

M+CO Contact Roles	Collection Level
Chief Executive Officer (CEO)	H Number
Chief Financial Officer (CFO)	H Number
Medicare Compliance Officer	H Number
Primary ACRP Contact	H Number
Medicare Coordinator	H Number
Systems Contact	H Number
ACR Audit Contact	H Number
ACR Audit Site Contact	H Number
Enrollment/Disenrollment Contact	H Number
PIP Contact	H Number
Customer Service	Plan
ACR Contact	Plan
PBP Contact	Plan
Vice President of Marketing	Plan

- Throughout the year, HCFA relies heavily on the contact information provided by M+COs in the General M+CO Information module within HPMS. HCFA uses this information to correspond with M+COs whenever important documents are sent or to resolve issues that may arise. In the event that the contact information provided in HPMS is not kept current, the resolution of critical matters or the receipt of important documents could be delayed. For example, the ACRP approval letters and any correspondence related to the ACR audits are sent to the CEO identified in this module. Failure to update the CEO contact information could delay the receipt of these items and reduce the amount of time allotted to respond. As a result, HCFA strongly encourages all M+COs to update contact information regularly in HPMS in order to establish better communication between HCFA and them.

- Plan Crosswalk. In CY 2001, M+COs were required to provide HCFA with an Excel spreadsheet that illustrated the CY 2000 to CY 2001 plan crosswalk. For CY 2002, the plan crosswalk feature has been incorporated into the HPMS ACRP upload process. The CY 2001 to CY 2002 plan crosswalk will assist HCFA during the review of plan marketing materials, particularly the Annual Notice of Change (ANOC) letter.

Description of an M+C plan

An M+C plan is the health benefits and pricing package that an M+CO offers beneficiaries the option to enroll in if they live in the plan's approved service area. M+COs can offer multiple M+C plans in the same or different service areas. Each M+C plan consists of basic benefits (Medicare covered benefits (Part A and B) plus additional benefits) and any mandatory and /or optional supplemental benefits. As described in the M+C regulations at 42 CFR 422.66, a beneficiary enrolls in a specific M+CO plan offered by an M+CO.

As was permitted last year, M+COs will determine how plans are transitioned/defined with respect to the Plan Identification number, within certain guidelines, from CY2001 to CY2002. M+COs may terminate particular M+C plans, add new M+C plans, or change benefits under existing M+C plans from one year to the next. The general guidelines for defining M+C plans from year to year are as follows:

1. If an M+CO designates that an M+C plan offered in 2001 will no longer be offered in 2002, then the M+CO must provide all beneficiaries enrolled in that plan with a letter detailing Medigap and Special Election Period rights.

2. If an M+CO designates that an M+C plan is continuing from CY2001 to CY2002 all beneficiaries enrolled in that plan in CY2001 must all be enrolled in the same plan for CY2002, unless they elect to disenroll or enroll in a different M+C plan.

3. If an M+CO splits a CY2001 M+C plan's service area into two or more CY2002 M+C plans, the M+CO may designate one of the CY2002 plans as a continuation of the original CY2001 plan. The enrollees in the continued portion of the service area would simply remain as enrollees of the plan in which they were enrolled in CY2001. The enrollees in the area now being served by a new second plan by definition are no longer enrolled in the continuing plan, and that plan has thus been terminated in their area. Regulations require that enrollees of a terminating M+C plan receive notice from the M+C organization 90 days before the termination date setting forth their Medigap rights. Under ordinary rules, such enrollees would be required to elect to enroll in the new M+C plan being offered in their area. HCFA is exercising its discretion to specify the manner in which elections are made by permitting these enrollees to be informed that they may make an "election" of the new M+C plan by taking no action. These enrollees must be informed that if they do not wish to elect the new plan, they should contact the M+CO, which must provide them with information on other available options (e.g., information on other M+C plans in their area, the Original Medicare Plan, and Medigap rights). In order for an enrollee to make an informed "election" under this process, the M+CO must send a modified ANOC to the enrollees setting forth the above information, as well as the benefits under the new plan. While this ANOC information ordinarily would not be due until a later date, if an M+CO wishes to avail itself of this approach to "elections," it must provide the ANOC information for the new plan by October 2, 2001, in order to meet the notice requirements for the original M+C plan's termination, and give the enrollees time to decide whether to "elect" the new plan by taking no action.

4. If an M+CO effectively combines two or more M+C plans into a single benefit package, by offering the same benefits under all existing plans, all enrollees of the plans would receive notice that they would receive the new single benefit plan in 2002. This situation would not constitute a termination giving rise to Medigap rights, as all plan enrollees would remain enrolled in a continuing plan.

Partial County Requests

The county integrity policy in the final rule affords HCFA broad discretion to approve partial counties. Such requests will be reviewed by HCFA on a case-by-case basis, and should be submitted to HCFA as soon as possible, but no later than June 1.

Multi-Year Benefits

On September 23, 1999, HCFA issued modified instructions regarding multi-year benefits in OPL #102, "Multi-Year Benefits under Medicare+Choice (M+C)". In general, describing a benefit as a multi-year benefit does not necessarily obligate the M+CO to continue offering the benefit after the contract year according to terms established for the first year. Organizations can, therefore, drop or modify multi-year benefits from year-to- year without maintaining obligations from the previous contract year.

We are concerned, however, that beneficiaries have appropriate information about the possibility that multi-year benefits, offered in a given year, may not be available in subsequent years. Therefore, M+COs are required to appropriately disclose this point wherever the multi-year benefit is mentioned. The following disclaimer may be used in marketing multi-year benefits:

"{Name of MCO]'s benefits are subject to change on annual basis; therefore multi-year benefits may not be available in subsequent years."

For the ACR, the actual and estimated costs of a multi-year benefit must be reported each year according to actual and estimated costs. As with all M+C benefits, drug coverage not used in one year cannot be carried over to another year. Regulations at 42 CFR 422.100(d) require that all benefits (including the amount of drug coverage) are uniform and available to all beneficiaries at the same premium and cost-sharing levels.

Changes in the Plan Benefit Package and Summary of Benefits

The Plan Benefit Package and Summary of Benefits have had substantial improvements made from CY2001 to CY2002. HCFA has worked with Industry representatives, including M+COs and Industry groups, over the past year to address problems with the PBP and the SB. HCFA has taken into consideration all of the requested changes, prioritized them, and either have made the changes for CY2002, will make the changes for CY2003, or will further review the requests to more fully understand the issues.

Some of the improvements that have been initiated and completed during the past year include the display of Optional Supplemental Benefits in both the Summary of Benefits and in Medicare Compare, the interval cost-sharing structure in Inpatient Hospital, Skilled Nursing Facility, and in the Mental Health service categories, the enhancements made in the copy function of the PBP, and the revision of the Point of Service benefit. The interval cost sharing structure will allow M+COs to specify, up to three intervals, different cost sharing structures depending on the days (Inpatient Services) or sessions (Mental Health Services) that the beneficiary utilizes. The Point of Service benefit has been reduced from 18 possible categories to one benefit category. That structure corresponds to the ACR worksheets.

Plan Benefit Package Certification Statement

After industry input and further consideration by HCFA, the Certification Statement in the PBP will not be required. The PBP software will still require that the Certification statement be viewed; however HCFA is not requiring any signatures or the submittal of the certification statement.

Benefit Package Design

M+COs must adhere to certain regulations when they design and develop benefit structures for each of their plans. The regulations include those ensuring that: the Medicare-covered services meet the HCFA fee-for-service coverage guidelines; the M+CO is not designing benefits to discriminate against beneficiaries who can be expected to have higher health care costs; and benefit designs meet other M+C program requirements.

It is HCFA's intent to review the impact of benefit designs on beneficiary elections. HCFA will be examining how the benefit design affects the enrollment of beneficiaries and access to services.

Medicare Health Plan Compare Data

"Medicare Compare" on the Internet

Starting on September 17, 2001, the CY 2002 health plan data will appear on "Medicare Compare" in the standardized summary of benefits format. In addition, "Medicare Compare" will continue to include graphs displaying several HEDIS and CAHPS measures, as well as disenrollment data.

Medicare & You 2002

It is expected that the health plan benefit and cost comparison information in *Medicare & You 2002* will be similar to the information provided in *Medicare & You 2001*. The HEDIS, CAHPS and disenrollment data will not be included in *Medicare & You 2002.*

Special Requirements for Section 1876 Cost Plans

HCFA will again display comparative information about Section 1876 Medicare cost contractors for CY 2002. To be included in HCFA's information, cost contractors must submit a PBP by July 2, 2001 for each benefit package they will offer in CY 2002. Benefit information about cost contractors who do not submit a PBP will not be included in *Medicare & You* or in "Medicare Compare."

Cost contractors who cannot submit a 2002 premium amount for their benefit packages in their PBP should send an email to Ana Nunez-Poole of the Center for Beneficiary Services at compchart@hcfa.gov. In this circumstance, M+COs should enter their CY 2001 premium amount in the PBP. Furthermore, *Medicare & You* will indicate "Not available" in the premium field and information in the "Medicare Compare" will remain blank.

Preview of Comparisons of Health Plans

Once again, HCFA has arranged to allow M+COs to preview their plan data before it is made available for public review. It is extremely important that M+COs carefully review all plan information before it is released for public comparison. To further prevent errors and delays in publication, all M+COs should carefully review the PBP data before it is submitted to HCFA. M+COs can preview their CY 2002 *Medicare & You* information on HPMS between July 18 - 24, 2001. "Medicare Compare" information should be previewed between September 4 - 6, 2001.

Marketing Issues

Additional Instructions for Marketing CY 2001 Benefits

CY 2001 Marketing Deadlines. The M+COs should cease using public media to market CY 2001 plans effective October 14, 2001. "Public media" includes billboards, radio, TV, print advertisements, and direct mail. "Medicare Compare" information for CY 2001, however, will continue to be accessible on the Internet until mid-December 2001.

M+COs should submit all remaining CY 2001 marketing materials to HCFA by no later than July 10. This deadline will allow HCFA to begin focusing resources on the review of marketing materials for CY 2002.

Effective September 1, all M+COs must include appropriate disclaimers in CY 2001 marketing materials as necessary. Disclaimers are required whenever an organization advertises a CY 2001 benefit, premium, or co-payment that will change effective January 1, 2002 (or whenever an organization accepts an election form for an effective date in 2002 after September 1). The disclaimer must be in the form of an attachment or an addendum to all marketing materials, including advertisements and enrollment election forms, that alerts potential members that changes will occur on January 1.

HCFA has provided the following model disclaimer to be used by all organizations. Additional regional office review and approval is not required if this disclaimer is used verbatim. HCFA review and approval is required if the language is modified. The following is to be used in marketing and enrollment beginning September 1, 2001, when changes will occur effective January 1, 2002:

"Benefits, premiums and copayments will change on January 1, 2002. Please contact [insert plan name] for details."

CY 2002 Summary of Benefits and Annual Notice of Change

For CY 2002, HCFA will again require all M+COs, Section 1876 cost contractors, and certain managed-care demonstration projects to use the standardized Summary of Benefits (SB) as part of the Annual Notice of Change (ANOC).

M+COs, cost contractors, and certain demonstration projects must use the SB and describe specific offerings of the January 2002 benefit and premium plans. A cover letter or ANOC letter that highlights the specific changes in benefits, premiums, and plan rules that will be effective on January 1, 2002, must accompany the SB. A model ANOC letter is contained in Attachment 3 of this OPL.

The ANOC and SB should be submitted to the regional office before September 1 to allow for review, approval and printing before October 15 - the date by which M+COs are required to notify current enrollees of changes to their plan. An organization is permitted to use a lower grade paper for the SB that they will use as part of the annual notification than the high-gloss paper they might ordinarily use when distributing the SB as a marketing piece.

If the organization lists only one plan in the SB, the ANOC must notify beneficiaries that additional plans are available, including specific information on how beneficiaries can obtain more details. If the M+CO lists more than one plan offering, it is required to identify the specific plan in which the member is currently enrolled on the cover letter transmitting the SB. Also, the M+CO must note in the ANOC that other plans are available in the service area and that these plans are listed on the enclosed SB.

Instructions for Marketing CY 2002 Benefits

Effective October 15, all M+COs that actively market M+C plans must begin using approved CY 2002 benefit package marketing materials. All marketing presentations and all mailings to Medicare beneficiaries concerning January 2002 enrollment (annual election period) must include a standardized SB describing January 2002 benefit package information. M+COs renewing M+C plans may continue to send and orally present CY 2001 plan information to individuals who specifically ask for it, and may continue to enroll individuals for effective dates before January 2002, based on the M+C plan being "open" and on other requirements of the law, regulations, and previously issued OPLs.

CY 2002 Evidence of Coverage (EOC)

The tentative deadline for distributing CY 2002 EOCs to all plan members is no later than January 15, 2002. All managed care organizations must also send an EOC to all new members no later than two weeks after their effective date of coverage (in January, they have until January 15 to provide the EOC to members who enrolled as of January 1).

HCFA plans to provide all M+COs with a new model CY 2002 EOC and a new checklist by mid-October this year. HCFA is planning to transition to a more user-friendly, standardized EOC document beginning in CY 2003 and will provide the document to M+COs in the Fall of 2002. All M+COs will be required to use the standard EOC in 2003, and will be given the

opportunity to provide input on its development, including participating in "Listening Sessions" and providing feedback on drafts of the EOC via the HCFA website.

As part of the transition to a standard EOC in 2003, HCFA plans to improve the CY 2002 model EOC so that it will contain more user-friendly language and layout/design. There will be several opportunities to provide input on the improved model. HCFA will post draft versions or sections of the model EOC on the HCFA Web site. All M+COs will be alerted via E-mail (through their Regional Office) when a new document is available for comment on the Web site, and will be given the opportunity to provide comments via a special address set up for this project (comments@standardeoc.org). At this time, we anticipate that draft versions or sections of the model will be posted on the Web site for comment in July and August.

Use of model CY 2002 EOC language is not mandatory, however it will facilitate the review of marketing materials. All other Medicare managed care organizations and demonstrations that are required to send an EOC to their members may base as much of the language of their EOC on this model as they can, since it is considered by HCFA to be acceptable language. Of course, these entities must modify any language in their respective EOCs to conform with the statutory and regulatory requirements under which they operate.

Marketing of Multiple Lines of Business under Medicare+Choice

M+C Organizations may market multiple lines of business in accordance with the following.

- Direct mail M+C marketing materials sent to current members describing other lines of business should contain instructions describing how individuals may opt out of receiving such communications. M+COs may apply this opt-out provision on an annual basis. The M+COs should make reasonable efforts to ensure that all individuals (including non-members) who ask to opt out of receiving future marketing communications, are not sent such communications.

- Although M+COs may market other lines of business concurrently with M+C products, information regarding the other lines of business must be separate and distinct from M+C plan information.

- M+COs should not include enrollment forms for non-M+C lines of business in any package marketing its M+C products, as beneficiaries might mistakenly enroll in the other option thinking they are enrolling in an M+C plan. Also, if information regarding M+C products and non-M+C lines of business are included in the same package, postage costs must be prorated so that costs of marketing non-M+C products are not included as "M+C plan-related" costs on Adjusted Community Rate (ACR) proposal submissions.

- M+COs may market other lines of business concurrently with M+C products on the Internet, though to avoid beneficiary confusion, M+COs must continue to maintain a separate and distinct section of their Web site for M+C plan information only.

- HCFA will review the M+CO's Web pages to ensure that M+COs are maintaining the separation between M+C plan information and information on other lines of business.

Value Added Items and Services (VAIS) in the SB

When applicable, organizations will be permitted to reference their pharmacy discount program (a VAIS) in Section 3 of their SB, provided they also include the following disclaimers (consistent with disclaimers outlined in the National Marketing Guide):

(1) This program is neither offered nor guaranteed under our contract with the Medicare program, but is available to all enrollees who are members of [Name of M+CO);
(2) This program is not subject to the Medicare appeals process. Any disputes regarding this program may be subject to the [Name of M+CO] grievance process; and
(3) Should a problem arise with this program, please call [Name of M+CO] for assistance at [M+CO customer service number]. Our customer service hours are [Enter hours].

In addition, the SB must clearly state (in the location that the program is described) that the program will be available for the entire contract year.

IV. List of Contacts

Election Periods for 2002: Lynn Orlosky, 410-786-5930.

ACR/PBP: For assistance in completing the CY 2002 ACR and PBP, please direct questions to ACR2002@hcfa.gov and PBP2002@hcfa.gov, respectively. HCFA will post and continually update a series of questions and answers about the ACRP process on www.hcfa.gov/medicare/acrp.htm.

Consolidation of ACR Cost Data: Please send all notices and questions regarding requests to consolidate ACR cost data to ACRCostCombine@hcfa.gov.

ACR Audit information: Kristin Finch, 410-786-2873

Extra Payment for CHF: Jane Andrews, 410-786-3133 or JAndrews@hcfa.gov

HPMS Help Desk: For technical assistance on HPMS and its technical processes, including the download and upload of ACRP submissions, please contact the HPMS Help Desk at either 1-800-220-2028 or hpms@nerdvana.fu.com.

HITS User IDs and Passwords: HPMS access requires a HITS user ID and password. Please contact Don Freeburger, Center for Health Plans and Providers, at either 410-786-4586 or DFreeburger@hcfa.gov to obtain a HITS user ID and password.

HPMS Voluntary Plan Closure Module: For questions on the upcoming HPMS Voluntary Plan Closure module, please contact either Lori Robinson, Center for Health Plans and Providers, at 410-786-1826 or LRobinson1@hcfa.gov or Ana Nunez-Poole, 410-786-3370 or ANunezpoole@hcfa.gov

2002 Plan Crosswalk: Christine Perenich, 410-786-2987

M+C Contract: Scott Nelson, 410-786-1038 or SNelson2@hcfa.gov

***Medicare & You* and "Medicare Compare:** Ana Nunez-Poole, 410-786-3370 or compchart@hcfa.gov.

Marketing Review: Please contact the appropriate HCFA regional office managed care staff with questions about the review of marketing materials. If necessary, regional office staff will forward these questions to HCFA central office staff for resolution.

Summary of Benefits: SB questions can be sent to: summaryofbenefits@hcfa.gov.

EOC: Questions or comments about the CY 2002 model EOC should be sent to comments@standardeoc.org. NOTE: HCFA will also receive any E-mails you send to this address. This E-mail address is the address of one of the contractors helping HCFA standardize the EOC. If you have comments on the standard EOC, this contractor will ensure that your comments are considered.

M+C Contractor Performance Monitoring System (MCPMS) Guide: Laura Minassian, 410-786-4641.

Encounter Data Attestations: Melissa Fannin, 410-786-0609

Appeals, Data: Brandon Bush, 410-786-0228

Appeals, Notices: Nydia Peel, 410-786-1619

Focused Review of Appeals Under Grijalva: Melodie Janes, 410-786-7614

HIPAA: Yolanda Robinson, 410-786-7627; Donna Dalfonzo-Wiggs, 410-786-9289; Cheryl Bitoun 410-786-7415

Important Message from Medicare: Rhonda GreeneBruce, 410-786-7579.

ATTACHMENT 1

APPEALS DATA REQUIREMENTS

The following data elements (currently being collected by M+COs as per OPL 99.081) will now also be required to be reported to HCFA:
(1) Time Period Covered: [Data Collection period].
(2) Total Number of Requests for an Appeal Received by MCO:[insert #].
(3) Average Number of Enrollees in MCO: [insert #].
(4) Total Number of Appeal Requests per 1,000 enrollees: [insert #].
(5) Of the Appeal Requests Received by MCO between [data collection period], MCO completed [insert #].

Of those cases (requests):
(6) [insert #] or [insert percentage] of the appeals were decided fully in favor of the enrollee;
(7) [insert #] or [insert percentage] of the appeals were not decided fully in favor of the enrollee;
(8) [insert #] or [insert percentage] were withdrawn by the enrollee;
(9) For all appeals received by MCO between [data collection period], [insert #] of cases sent to the Independent Review Entity (IRE) for review.

Of those cases (requests):
(10) [insert #] or [insert percentage] of MCO's cases reviewed by the IRE were decided fully in favor of the enrollee.
(11) [insert #] or [insert percentage] of MCO's cases reviewed by the IRE were not decided fully in favor of the enrollee.
(12) [insert #] or [insert percentage] were withdrawn by the enrollee;
(13) [insert #] or [insert percentage] are still awaiting a decision by the IRE.

In certain situations, the M+C organization is required to process an appeal faster than usual because delay in making a decision could cause serious harm to the enrollee. This is called an expedited appeal. In many cases, it is the M+C organization that decides whether or not to expedite the appeal.

(14) Between [data collection period], MCO received [insert #] requests for expedited processing of appeals.

Of those cases (requests):
(15) [insert #] or [insert percentage] of the requests for expedited processing of the appeal were granted;

(16) [insert #] or [insert percentage] of the requests for expedited processing of the appeal were not granted.

ATTACHMENT 2

Important Message from Medicare

Patient=s Name:_____

Date of Notice:_____

Medicare # (HICN):_____

Attending Physician:_____

Hospital:_____

ADMISSION NOTICE OF YOUR RIGHTS AS A HOSPITAL PATIENT

- **$** You have the right to receive necessary hospital services covered by your Medicare Health Plan ("your Plan").
- **$** You have the right to know about any decisions that the hospital, your Plan, or anyone else makes about your hospital stay and who will pay for it.
- **$** Your Plan or the hospital should arrange for services you will need after you leave the hospital. Your Plan may cover some care in your home (home health care) and other kinds of care, if ordered by your doctor or plan. You have a right to know about these services, who will pay for them, and where you can get them. If you have any questions, you should talk to your doctor or Health Plan.
- **$** Before you leave the hospital, you or your authorized representative will be given this notice again with the blank spaces below filled in. You will then be asked to sign that you have received this notice.

INFORMATION ABOUT YOUR HOSPITAL DISCHARGE

Your doctor has reviewed your medical condition and has determined that you can be discharged from the hospital because:

- **G** You no longer require inpatient hospital care.
- **G** You can safely get any medical care you need in another setting.
- **G** Other: _____.

This means that, if you stay in the hospital, it is likely that your hospital charges for _____ and thereafter will not be covered by your Plan.

$ If you think you are being asked to leave the hospital too soon, you have the right to appeal to your Peer Review Organization (also known as a PRO). The PRO is authorized by Medicare to provide a second opinion about your readiness to leave the hospital. The name of the PRO is _____.

You may contact the PRO at _____.

$ If you ask the PRO for a fast appeal while you are in the hospital by noon of _____, you will not be responsible for paying the hospital charges until the PRO makes a decision within one day after receiving all the information needed to make a decision.

$ If you miss the deadline for filing for a fast review, you may still request a fast review by your Plan. However, you may be responsible for paying the costs of your hospital stay beginning _____. A Plan "fast review" means a review may be done within 72 hours.

$ You may file for review at the address or telephone number of your Plan:

_____

_____

Please sign below to show you received this notice before leaving the hospital and the date you signed it.

_____

_____

Signature of Medicare patient or authorized representative Date of signature

OMB Approval No. 0938-0692. HCFA-R-193-M+C

ATTACHMENT 3

MODEL ANNUAL NOTICE OF CHANGE (ANOC) - January 1, 2002

Date: [No later than] October 15, 2001

Member Name, Medicare Number
Address
Member Number
Health Plan Name

Dear (member name):

Starting January 1, 2002, the monthly premium that you pay to {Health Plan Name} will (increase/decrease) from $____ to $____ **OR** (stay the same at $____).

[*M+COs that wish to provide for enrollees of a terminated M+C plan to "elect" a different M+C plan by taking no action (see section III.) must insert the following information.* The notice must inform enrollees that if they wish to enroll in the M+C plan in question, they need take no action, and they will be enrolled in that plan effective January 1. The notice must also provide instructions on how these enrollees can choose not to elect the other M+C plan (i.e., by indicating that they do not wish to make this election, which would return them to Original Medicare, or by electing a different plan), and must provide information on the enrollee's Medigap rights, which apply if they do not elect the other M+C plan offered by the M+CO.]

[*If the organization lists more than one plan offering on the enclosed SB, the organization must identify the specific plan in which the member is currently enrolled. In addition, if the organization lists only one plan in the SB but offers multiple plans in the service area, the ANOC must notify beneficiaries that additional plans are available and include specific information on how beneficiaries can obtain more information. If the M+CO lists more than one plan offering on the SB enclosed with the Annual Notice of Change (ANOC), it is required to identify the specific plan in which the member is currently enrolled on the cover letter transmitting the SB, and to note in the ANOC that other plans are available in the service area and that these plans are listed on the enclosed SB.]

Medicare has reviewed and approved the changes to the benefits, premiums, copayments and plan rules in this letter and on the enclosed Summary of Benefits. All changes begin January 1, 2002, and will be in effect through December 31, 2002.

[Clearly describe all benefit changes, including changes in copayments, annual drug cap, drug coverage [formulary/generic], and any new benefits that will be offered by the plan in 2002 or that will be covered by Medicare. Also describe any benefits offered in 2001 that will no longer be offered by the plan in 2002. Organizations that do not include an SB, which describes all

plans, offered by the organization must include a statement that additional plans are available with information for the beneficiary on how to get further details].

[Clearly describe any optional supplemental benefits and the premiums for those benefits. A description of the process that the member must follow to elect optional supplemental benefits must also be included.]

[All M+C Organizations include the following paragraph. (This paragraph does not apply for plans operating under 1876 rules)] Now is a good time to review your coverage with {M+C Name}. A new law has passed that says that between January 1 and June 30, 2002, you can only leave or join a plan once, including leaving a plan to be in Original Medicare. After that, you must stay with your plan for the rest of the year. In certain cases, like if you move, you may be able to choose another plan.

A new Evidence of Coverage (is enclosed) **OR** (will be sent to you by mid-January). A Summary of Benefits is also enclosed. We are required to use the Summary of Benefits for both current members, like you, as well as for people who are thinking about enrolling in {Health Plan Name}. This means that some of the language at the beginning of the document may make it seem like you are not already a member of {Health Plan Name}. Rest assured that you are a member of {Health Plan Name} and will be one for the coming year if you do nothing to change your Medicare coverage.

The following information is available upon request:

- Additional information from HCFA by calling 1-800 MEDICARE.
- Additional information from {Health Plan Name} on the procedures we use to control utilization of services and expenditures.
- Additional information on the number and disposition in aggregate of grievances and appeals filed by members of {Health Plan Name}.
- A summary description of the method of compensation for physicians used by {Health Plan Name}.
- A description of our financial condition, including a summary of our most recently audited statement.

If you have any questions about these changes or if you would like additional information, please call our Member Services Department, Monday through Friday, (hours of operation) on (health plan phone number). [Include a TTY/TDD phone number "for the hearing impaired."]
We look forward to serving you now and in the future.

Sincerely,

Plan Representative

ENCLOSURE - 1/2002 Summary of Benefits

ATTACHMENT 4

DEPARTMENT OF HEALTH & HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

Center for Health Plans and Providers
Medicare Managed Care Group
7500 Security Blvd.
Baltimore, MD 21244

Fax (410) 786-8933

From: Gary Bailey
Acting Director
Medicare Managed Care Group

Subject: Question and Answer Session on the 2002 OPL

To: Medicare+Choice Organizations and other Interested Parties

We are pleased to announce an opportunity for Medicare+Choice Organizations to discuss with HCFA staff the 2002 OPL. The conference call will be on **Tuesday, May 1st from 12:30 p.m. until 2:00 p.m. (EST)**. The conference call dial-in number is **1-888-587-0679** and the conference ID number is **321163.**

The format of the call will be as follows:

Introduction and Timeline
Questions and Answers:
Summary of Important Changes and Renewal Process
CBS (approximately 12:30pm-1:15pm)
CHPP/OACT (approximately 1:15pm-2:00pm)

We look forward to your organization's participation.

Special Note:
If you are unable to attend the conference, for your convenience we have arranged for an Encore Feature Service. This service gives you a recorded playback of the entire call. This feature is only available for up to 48 hours after the conference call. The toll-free # for the Encore feature is 1-800-642-1687. The operator will prompt you to key in the conference ID, which is **321163.** You should then be able to hear the recorded conference call!